RESIDENTS OF IOWA

I understand that according to Iowa Code CH 228 that I may review the disclosed information by contacting the agency or individual releasing the information. I understand that I have a right to a copy of this Form-827

_____ Yes, I want a copy

_____ No, I do not want a copy

Form Approved
OMB No. 0960-0623

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 7332.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE

STREET ADDRESS	TELEPHONE NUMBER (Area Code)

CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS

CITY	STATE	ZIP CODE

Explanation of Form SSA-827-OP2, Authorization For Source to Release Information to the Social Security Administration (SSA)

We are requesting that you authorize the release of information about your impairment to us. Sources usually require this authorization before releasing information to us. Also, the law requires this authorization for release of information about certain conditions.

You can provide this authorization by signing a Form SSA-827-OP2, Authorization For Source to Release Information to the Social Security Administration (SSA), for each source identified during your disability interview or during the processing of your claim. We must inform you that because of various Federal disclosure laws, SSA cannot give an absolute pledge of confidentiality regarding information submitted in connection with your claim.

PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows:

(1) To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

(2) To comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and

(3) To facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 3 minutes to read the instructions, gather the necessary facts, and answer the questions.